

Patient Information & Authorization

PATIENT NAME \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State/Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Employment \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail \_\_\_\_\_

HUSBAND/PARENT \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State/Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Employment \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

EMERGENCY CONTACT #1 \_\_\_\_\_ Phone \_\_\_\_\_

EMERGENCY CONTACT #2 \_\_\_\_\_ Phone \_\_\_\_\_

Family Physician \_\_\_\_\_ Religion \_\_\_\_\_

MEDICAL ALLERGIES \_\_\_\_\_

PHARMACY USED MOST FREQUENTLY \_\_\_\_\_

INSURANCE

Policy Holder \_\_\_\_\_ Ins. Company \_\_\_\_\_

ID No. \_\_\_\_\_ Group No. \_\_\_\_\_

**AUTHORIZATION TO MAIL, CALL or E-MAIL**

I certify that I understand and am responsible for the privacy risks of the mail, phone calls, and e-mails. I hereby authorize a representative or physician of this office to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying this office to that effect in writing.

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

**MEDICARE BENEFICIARY SIGNATURE ON FILE FORM**

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or Carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

**M.TERRY JEPPSON M.D. FACOG**  
**OFFICE INSURANCE POLICY**

**PLEASE SHOW YOUR INSURANCE CARD TO THE RECEPTIONIST**

I do understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account. I agree to pay ALL re-billing charges, interest charges, collection cost and reasonable legal fees. I request that payment under the medical insurance program be made to the provider of medical services. I authorize the provider to release to my insurance carrier any information needed for those claims.

As a courtesy to our patients, we submit to their primary and secondary insurance companies as long as the information provided to us by the patient is correct. Please remember that professional services rendered are charge to the **patient** and **not** to the insurance company. Even though an insurance claim is filed, you will still receive a statement each month if your account has a balance. This office will not accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.

Please be aware that contractual adjustment will only be deducted for insurance companies that this office has a contract with. If we are not a participating provider no contractual adjustment will be made.

Full payment is expected at the time services are rendered, unless credit arrangements have been set up in advance (please ask to speak to the Office Manager). Health insurance is a contract between you and your insurance company and does not create a credit in this office. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, and secondary insurance ect. other than to supply factual information as necessary.

**FINANCE CHARGES**

If for some reason we allow you to have a balance with us, at our discretion, there will be a 1.50% interest charge per month for accounts over 60 days.

By signing this policy you agree that (regardless of your insurance status), you are ultimately responsible for the balance on your account. You agree to pay ALL fees.

\_\_\_\_\_  
**PATIENT/RESPONSIBLE PARTIES SIGNATURE**

\_\_\_\_\_  
**DATE**

I have received a copy of Dr. M. Terry Jeppson's privacy policy.

\_\_\_\_\_  
**PATIENT/RESPONSIBLE PARTY SIGNATURE**

\_\_\_\_\_  
**DATE**

M. Terry Jeppson M.D., FACOG  
Confidential History and Physical Form

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_

Referred to our office by: \_\_\_\_\_

**Your Reason for coming to see the Physician:**

**Gynecology History:**

When was the first day of your last menstrual period? \_\_\_\_/\_\_\_\_/\_\_\_\_

Was it a normal period? Y or N

How old were you when you started menstruating? \_\_\_\_\_

Are your cycles regular? Y or N # of days from start of one period to the next \_\_\_\_\_

Number of days Period lasts \_\_\_\_\_

Have you ever been treated for abnormal uterine bleeding? Y or N Explain: \_\_\_\_\_

Are you currently on hormones? Y or N Prescription: \_\_\_\_\_

Have you taken hormones or birth control pills in the past? Y or N List: \_\_\_\_\_

Are you sexually active? Y or N What are you currently using for birth control? \_\_\_\_\_

How many partners do you currently have? \_\_\_\_\_ Total partners lifetime \_\_\_\_\_ M or F \_\_\_\_\_

Have you ever had an abnormal Pap Smear? Y or N Treatment: \_\_\_\_\_

Have you ever been treated for any sexually transmitted diseases? Y or N Types \_\_\_\_\_

Do you have problems with recurrent yeast or vaginal infections? Y or N Explain: \_\_\_\_\_

Have you ever been sexually abused? Y or N \_\_\_\_\_

Do you have a family history of Breast Cancer? Y or N Whom \_\_\_\_\_

Do you practice Breast self exam? Y or N Have you had a mammogram? Y or N When \_\_\_\_\_

**Obstetric History:**

Total number of living children: \_\_\_\_\_ Any twins? Y or N Adopted children? Y or N

Were your deliveries: # \_\_\_\_\_ Full Term, # \_\_\_\_\_ Pre-Term

Of those deliveries: # \_\_\_\_\_ Vaginal, # \_\_\_\_\_ C-Section,

Have you had any miscarriages? Y or N How many? \_\_\_\_\_

Any terminations? Y or N How many? \_\_\_\_\_

Any tubal pregnancies? Y or N How many? \_\_\_\_\_

How many total pregnancies have you had? \_\_\_\_\_

**Medical History:**

How would you describe your current health?

**Do you have any of the following:** (Circle any that apply)

Anemia	Arthritis	Asthma	Cancer
Diabetes	Epilepsy	Hay Fever	Heart Trouble
Liver Disease	Kidney Disease	High Blood Pressure	
Rheumatic Fever	Stomach Ulcers	Thyroid Problems	Cholesterol Elevation

Other: \_\_\_\_\_

**ALLERGIES or REACTIONS TO MEDICATIONS:** (Please list name and type of teach reaction)

\_\_\_\_\_  
\_\_\_\_\_  
Medications or Supplements you are currently taking, including dosage and frequency: (Please use the back of this paper if necessary)

M. Terry Jeppson M.D., FACOG  
Confidential History and Physical Form

**Surgical History:**

Please list any surgical procedures you have had: (Please include date or age, name or procedure performed, and physician performing surgery; if known)

**Social History:**

Marital Status: S M D W

Are you employed? Y or N Where? \_\_\_\_\_

What is your level of education? \_\_\_\_\_

Have you ever smoked? Y or N

Do you currently smoke? Y or N If yes, how much per day? \_\_\_\_\_

Do you drink alcoholic beverages? Y or N How much and how often? \_\_\_\_\_

Have you ever used recreational drugs? Y or N If yes, what? \_\_\_\_\_

Do you currently use recreational drugs? Y or N If yes, what? \_\_\_\_\_

**Family History**

Does anyone in your family have health related problems? Explain:

Father \_\_\_\_\_

Paternal Grandmother: \_\_\_\_\_

Mother \_\_\_\_\_

Paternal Grandfather: \_\_\_\_\_

# \_\_\_\_\_ Brothers: \_\_\_\_\_

Maternal Grandmother: \_\_\_\_\_

# \_\_\_\_\_ Sisters: \_\_\_\_\_

Maternal Grandfather: \_\_\_\_\_

Do twins run in your family? Y or N

Any Birth Defects in your family? Y or N Explain:

---

**For Office Use:**

Vital Signs: Wt. \_\_\_\_\_, Ht. \_\_\_\_\_, BMI: \_\_\_\_\_, T: \_\_\_\_\_ P: \_\_\_\_\_ R: \_\_\_\_\_ BP: \_\_\_\_\_ Pain: \_\_\_\_\_